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ABSTRACT

This report summarizes the deliberations, findings, and recommendations of the National Commission on Adolescent Sexual Health. The report defines the characteristics of a sexually healthy adolescent, provides a foundation for understanding the three developmental stages of adolescents (early, middle, and late adolescence), and offers recommendations for policymakers, parents, educators, health professionals, and the media. A statement reflecting the consensus of the commission is included, with a list of national organizations that have endorsed the statement. The background of the consensus statement discusses adolescent development, characteristics of a sexually healthy adolescent, adolescent sexual behavior in the 1990s, and the adult role in promoting adolescent sexual health. Recommendations for policymakers include: (1) recognize that sexual development is an essential part of adolescence and develop public policies consistent with research about adolescent development, adolescent sexuality, and program effectiveness; (2) support parents and families as integral members of efforts to improve adolescent sexual health; (3) support comprehensive sexuality education, which includes human development, relationships, personal skills, sexual behavior, sexual health, and sexuality and culture; (4) provide a full range of confidential sexual and reproductive health services tailored for adolescents and encourage cultural messages that support sexual health and responsible sexual relationships; (5) support research on adolescent sexuality and provide funding for coordinated and integrated adolescent programs; (6) respond to the diverse sexual health needs of adolescents, including the disenfranchised, disabled, and gay and lesbian adolescents; (7) involve youth in program planning and implementation; and (8) value and respect adolescents. Additional readings and biographical sketches of the commissioners are included. (Contains 43 references.) (ND)

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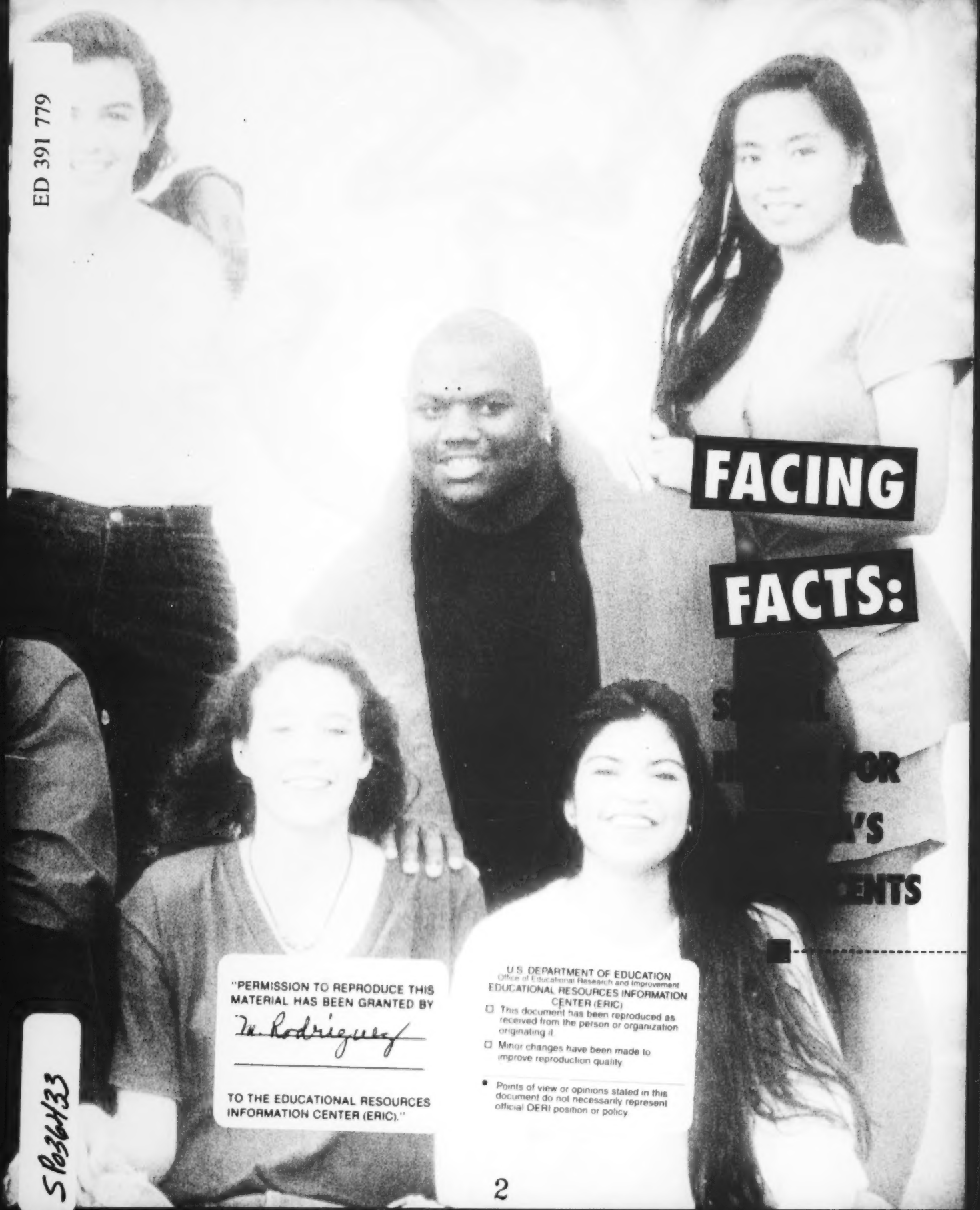

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THE REPORT OF THE NATIONAL COMMISSION ON ADOLESCENT SEXUAL HEALTH

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SEXUAL HEALTH FOR AMERICA'S ADOLESCENTS

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National Commission on
Adolescent Sexual Health

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This report is the result of the deliberations of the National Commission on Adolescent Sexual Health. Commissioners volunteered their time to participate in meetings, contribute ideas, review documents, and offer feedback. The report emerged as a consensus of the members of the Commission. It could not have been completed without their assistance.

Dr. Robert Johnson, director, adolescent medicine, New Jersey Medical School, chaired the Commission. Dr. Johnson chaired the meetings, reviewed countless drafts of the report, and offered invaluable feedback and suggestions. This project could not have happened without his commitment.

Ilene Wachs completed the extensive literature review for the project, including developing the project bibliography.

Betsy Wacker coordinated the Commission project. She arranged the meetings, compiled the literature for the review, compiled the briefing book for the Commission members, and worked diligently on the preparation of this report.

Daniel Daley, Dore Hollander, Leslie Kantor, and Valarie Morris, SIECUS staff members, also played important roles in the project. Erika Mathews compiled the references and reworked countless drafts.

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INTRODUCTION

More than nine in ten American adolescents experiment with sexual behaviors.

By the time they turn age 20, more than three-quarters of American young women and young men have had sexual intercourse.

Every year, one million U.S. teenage women become pregnant, more than half a million have a child, and three million teenage men and women acquire a sexually transmitted disease.

Adolescent sexuality has changed dramatically during the past 40 years. In the 1950s, petting was the most common intimate teenage sexual experience, adolescents reached physical maturity later and married earlier, and teenage intercourse was uncommon except among the oldest and often engaged or married adolescents. Patterns of sexual behavior differed widely among young men and young women, as well as among youth from different backgrounds.

Today's teenagers reach physical maturity earlier and marry later. There has been a steady increase in the percentage of young people having sexual intercourse, and in the percentage doing so at younger and younger ages. Almost all teenagers experiment with some type of sexual behavior. Patterns of sexual activity are now fairly similar among young men and women, and young people from different ethnic, socio-economic, and religious groups.

There is public and professional consensus about what is sexually unhealthy for teenagers. Professionals, politicians, and parents across the political spectrum share a deep concern about unplanned adolescent pregnancy; out-of-wedlock childbearing; sexually transmitted diseases (STDs) including AIDS; sexual abuse; date rape; and the potential negative emotional consequences of premature sexual behaviors.

However, there is little public, professional, or political consensus about what is sexually healthy for teenagers. The public debate about adolescent sexuality has often focused on which sexual behaviors are appropriate for adolescents, and ignored the complex dimensions of sexuality.

Some groups support the "just say no" approach to adolescent sexuality. They believe that the only healthy adolescent sexuality is abstinence from all sexual behaviors until marriage, and that adults should work to eliminate teen sexual experimentation.

Another approach could be described as "just say not now." This philosophy encourages young people to abstain until they are more mature, but given the high rates of teenage sexual involvement in intercourse, recommends that it is important to provide young people with access to contraception and condoms whether or not adults approve of their behavior. This approach might also be labeled "if you can't say no, protect yourself!"

Other adults adopt a "don't ask, don't tell" posture, and simply pretend that adolescent sexuality and sexual behavior do not exist.

"The world has changed. The word sex is not a bad word today. It's talked about very openly. And that is a good thing."
Mandy, H.S. Senior, WI

In 1994, SIECUS convened the National Commission on Adolescent Sexual Health. The Commission believes there is an urgent need for a new approach to adolescent sexual health. Society has a responsibility to help adolescents understand and accept their evolving sexuality and to help them make responsible sexual choices, now and in their future adult roles. The Commission believes that adults must focus on helping young people avoid unprotected and unwanted sexual behaviors. Individual adults and society in general must help adolescents develop the values, attitudes, maturity, and skills to become sexually healthy adults.

This report summarizes the deliberations, findings, and recommendations of the National Commission on Adolescent Sexual Health. The report is presented as a consensus and is not intended to represent the individual views of Commissioners nor their institutional affiliations.

Audience: This report is designed to be a guide for policy makers. Although it may provide insights to health and education practitioners, as well as parents of adolescents, it is written primarily to help national, state, and local policy makers develop sound policies on adolescent sexual health. The Commission believes that public policies on adolescent sexual health should be based on knowledge of adolescent development, accurate data, an established theoretical basis for program effectiveness, ongoing evaluation, and adequate funding and support.

Assumptions: The reader should keep in mind several assumptions that underlie this report:

1 **Sexuality is a natural and healthy part of life.** Sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. It deals with the anatomy, physiology, and biochemistry of the sexual response system, as well as with roles, identity, and personality. Sexuality encompasses thoughts, feelings, behaviors, and relationships.

All human beings are inherently sexual. Infants, children, adolescents, and adults at different stages experience their sexuality in distinct ways. Sexuality evolves during childhood and adolescence, laying the foundation for adult sexual health and intimacy. Adolescent sexual health is defined by a broad range of knowledge, attitudes, and behaviors, and cannot be defined solely on the basis of abstinence or preventive behaviors.

2 **Adolescent sexuality is a highly charged emotional issue for many adults.** All adults are former adolescents, and one's own personal biography often colors the understanding of this complex issue. Most of the members of the Commission--as well as many of the readers of this report--are parents of preadolescents, adolescents, or young adults. Commission deliberations often started with discussions about what individuals hoped for their own children. Policy makers are urged to understand the context of contemporary adolescents as they read this report.

3 Adolescents in the United States grow up in a variety of contexts and communities. The Commission struggled to define adolescent sexual health in its broadest context while respecting the difficulty of generalizing to our complex society. Young people who face special physical, mental, emotional, social, cultural, and economic challenges confront a wide range of barriers to sexual health and require priority attention.

4 "Sexual behavior," as used in the report, is not synonymous with heterosexual penile-vaginal intercourse. The Commission emphasizes that sexual behavior can include a range of physical acts, such as masturbation; kissing; holding hands; touching; caressing; massage; and oral, vaginal, or anal intercourse. In addition, the Commission recognizes that these behaviors may take place with a partner of the same or other gender. The term "sexual intercourse" is used explicitly in the report to refer to any type of vaginal, oral, or anal intercourse. Unless specified, the discussion in this report includes youth of all sexual orientations.

5 The available research on healthy adolescent sexuality is extremely limited. Although data are presented in the sections that follow, the Commission recognizes that most of the existing research has focused on adolescent women, particularly those who attend family planning clinics, and on the morbidities associated with adolescent sexual behavior. Most studies have examined heterosexual intercourse and contraceptive practices. Few studies are available on the context of adolescent romantic relationships, noncoital behaviors, and healthy adolescent sexual relationships. Further, research is usually available only on European-American and African-American adolescents, and information on education or income is often unavailable.

6 The Commission recognizes the very serious morbidities related to adolescent sexual behavior and their negative impact on adolescents. There are many excellent reports on adolescent pregnancy and sexually transmitted diseases, including AIDS. This report concentrates on what is sexually healthy for adolescents, and does not repeat the information the reader can find elsewhere. For a list of recommended reading in this area, see Additional Readings on page 28.

"Most adults think that just because you ask about it, it means you're going to go out and do it."

Teen male, 16, D.C.

CONSENSUS STATEMENT ON ADOLESCENT SEXUAL HEALTH

This statement reflects the consensus of the National Commission on Adolescent Sexual Health. Each point is explored in greater depth in the Consensus Statement: Background section of this report. The Consensus Statement has been endorsed by 48 national organizations.

Becoming a sexually healthy adult is a key developmental task of adolescence. Achieving sexual health requires the integration of psychological, physical, societal, cultural, educational, economic, and spiritual factors.

Sexual health encompasses sexual development and reproductive health, as well as such characteristics as the ability to develop and maintain meaningful interpersonal relationships; appreciate one's own body; interact with both genders in respectful and appropriate ways; and express affection, love, and intimacy in ways consistent with one's own values.

Adults can encourage adolescent sexual health by:

- Providing accurate information and education about sexuality;
- Fostering responsible decision-making skills;
- Offering young people support and guidance to explore and affirm their own values; and
- Modeling healthy sexual attitudes and behaviors.

Society can enhance adolescent sexual health if it provides access to comprehensive sexuality education and affordable, sensitive, and confidential reproductive health care services, as well as education and employment opportunities.

Families, schools, community agencies, religious institutions, media, businesses, health care providers, and government at all levels have important roles to play.

Society should encourage adolescents to delay sexual behaviors until they are ready physically, cognitively, and emotionally for mature sexual relationships and their consequences.

This support should include education about:

- Intimacy;
- Sexual limit setting;
- Resisting social, media, peer, and partner pressure;
- Benefits of abstinence from intercourse; and
- Pregnancy and sexually transmitted disease prevention.

Society must also recognize that a majority of adolescents will become involved in sexual relationships during their teenage years. Adolescents should receive support and education for developing the skills to evaluate their readiness for mature sexual relationships. Responsible adolescent intimate relationships, like those of adults, should be based on shared personal values, and should be:

- Consensual;
- Nonexploitative;
- Honest;
- Pleasurable; and
- Protected against unintended pregnancies and sexually transmitted diseases, if any type of intercourse occurs.

THE FOLLOWING NATIONAL ORGANIZATIONS HAVE ENDORSED THIS CONSENSUS STATEMENT.

Advocates for Youth

AIDS Action Council

American Association of Family and Consumer Sciences

American Association on Mental Retardation

American Association of Sex Education, Counselors, and Therapists

American Association of University Women

American College of Obstetricians and Gynecologists

American Counseling Association

American Medical Association

American Orthopsychiatric Association

American School Health Association

American Social Health Association

Association for the Advancement of Health Education

Association of Reproductive Health Professionals

AVSC International

Blacks Educating Blacks About Sexual Health Issues

Catholics For A Free Choice

Child Welfare League of America

Education Development Center, Incorporated

ETR Associates

Federation of Behavioral, Psychological and Cognitive Sciences

Girls Incorporated

Hetrick-Martin Institute

Human Rights Campaign Fund

Latina Roundtable on Health and Reproductive Rights

National Abortion Federation

National Abortion and Reproductive Rights Action League

National Asian Women's Health Organization

National Association of School Psychologists

National Center for Health Education

National Coalition of Advocates for Students

National Council of the Churches of Christ, Commission on Family Ministries and Human Sexuality

National Education Association - Health Information Network

National Family Planning and Reproductive Health Association

National Lesbian and Gay Health Association

National Minority AIDS Council

National Native American AIDS Prevention Center

Parents, Families and Friends of Lesbians and Gays

Planned Parenthood Federation of America

Religious Coalition for Reproductive Choice

Sexuality Information and Education Council of the United States

Society for Adolescent Medicine

Society for the Scientific Study of Sex

The Alan Guttmacher Institute

Unitarian Universalist Association

United Church Board for Homeland Ministries

Y.W.C.A. of the U.S.A.

Zero Population Growth

ADOLESCENT DEVELOPMENT

Becoming a sexually healthy adult is a key developmental task of adolescence. Achieving sexual health requires the integration of psychological, physical, societal, cultural, educational, economic, and spiritual factors.

Discussions about adolescent sexuality often are predicated on an adult perception of how "things should be," rather than on an appreciation of the dynamics and goals of adolescent development and maturation.

Adolescence is the time when young people develop the knowledge, attitudes, and skills that become the foundation for psychologically healthy adulthood. Although it is beyond the scope of this document to fully elaborate on adolescent development, this chapter will give policy makers a basic introduction to adolescence.

Adolescence is a period characterized by rapid changes and the need to achieve many significant developmental tasks. Nevertheless, far from being a time of great conflict and distress, the majority of adolescents pass through adolescence successfully. Children who enter adolescence with the most social or psychological disadvantages are likely to experience the greatest difficulties. Indeed, it may be that the greatest barrier to healthy development is a lack of education and economic opportunities. (Peterson and Leffert, 1994)

THE THREE STAGES OF ADOLESCENCE

Developmental psychologists and health professionals have categorized adolescence into three developmental stages: early adolescence, middle adolescence, and late adolescence. These stages are key to understanding adolescents' behavioral decisions and adolescent sexuality. TABLE I summarizes these stages.

While reading this section, it is important to remember that there is no such thing as an "average adolescent." Individual adolescents vary widely in the pace of their development. For example, in any group of thirteen-year-olds, some might function as nine-year-olds, and some as sixteen-year-olds. There is also a high degree of variation within each adolescent: for example, a physically mature fifteen-year-old might function emotionally as a twelve-year-old in dealing with his parents, and yet cognitively as a late adolescent in dealing with math problems.

Adolescent growth and development--and adolescent sexuality--is not singular or stable. It is plural and dynamic. For most young people, adolescence does not entail an absolutely predictable, consistent set of developmental tasks, nor does it unfold in a singular, universal fashion. Adolescent sexuality emerges from cultural identities mediated by ethnicity, gender, sexual orientation, class, and physical and emotional capacity. (Carrera, 1981; Irvine, 1994) Adolescent development is affected by parents, other family members, and other adults, as well as schools and the peer group.

EARLY ADOLESCENCE

The young adolescent experiences body changes more rapidly than at any time since infancy--secondary sexual characteristics begin to appear; growth accelerates; and physical changes require psychological and social adjustments on the part of the adolescent, family, and other adults. These young people are often concrete thinkers and therefore have difficulty projecting themselves into the future. This phenomenon is problematic when young people are asked to modify their behaviors and delay gratification to achieve a distant future goal. The young adolescent is beginning to separate from the family, but usually values parental guidance on important issues. Conflicts with parents usually peak at the height of these pubertal changes, yet only 15 percent of teenagers and their parents will experience a severe disruption in the parent-child relationship. (Peterson and Leffert, 1994) Peer norms, especially identification with a particular group or set of groups, assume increasing importance.

Experimenting with some sexual behaviors is common, but sexual intercourse of any kind is usually limited. Males may initiate intercourse during this stage, but most often delay regular sexual activity until middle or late adolescence. Adolescent girls are much less likely to begin sexual intercourse at this age. Of those who do, many are in relationships with much older men. (See Box on page 19.)

Young adolescents seek to develop a sense of identity, connection, power, and joy. For many adolescents from communities that do not support the development of personal identity in other ways, drugs and sexual experimentation may be a short cut to provide these feelings. Early sexual involvement is one way that disadvantaged youth may meet developmental needs for power, identity, connection, and pleasure. (Selverstone, 1989) Involvement in sexual behaviors may not be about sexual pleasure, but rather may reflect peer norms, boredom, conflicts with adults, low self-esteem, and poor ability to control impulsivity. (Durban, DiClemente, and Siegel, 1993)

MIDDLE ADOLESCENCE

Middle adolescence is the stage that most typifies the stereotype of "teenagers." The transitions in this stage are so dramatic that they seem to occur overnight. The secondary sexual characteristics become fully established, and for girls, the growth rate decelerates. Abstract thought patterns begin to develop in significant proportions of middle adolescents.

Middle adolescents are sometimes described as feeling omniscient, omnipotent, and invincible. These feelings provide young people with the support to develop greater autonomy, but may also put them at risk. Although recent studies suggest that adolescents feel no more invincible than adults who are risk takers (Quadrel, et al. 1993), a sense of invincibility, coupled with a developing ability to predict consequences, allows some adolescents to participate in risk taking behaviors and believe that they cannot be harmed--for example, "I can drive a car

"Hanging with a tough crowd made me feel cool...when I was with my homegirls, I felt like I was the coolest person on Earth."

Evelyn, 18, CA

even though I have never taken a driving lesson"; "I can stop a bullet and not die"; "I can have unprotected sexual intercourse and not become pregnant or get HIV."

As adolescents continue the process of separation from the family, they cling more tightly to the peer group that they defined for themselves in early adolescence. The peer group begins to define the rules of behavior. Parents' values on longer term issues such as the importance of education and career preparation are generally stronger than peer values on the same issues. However, the desire to be accepted by the peer group often influences such issues as experimentation with drugs or sexual behaviors. By its acceptance or rejection, the peer group acts to affirm the adolescent's self-image.

Sexuality and sexual expression are of major importance in the lives of many middle adolescents. As they move through rapid developmental changes, adolescents at this stage often focus on themselves and assume others will equally focus on them. Many middle adolescents choose to show off their new bodies with revealing clothes such as miniskirts and muscle shirts. Although adults may define this as sexually provocative, this may be more the adult's perception than the intent of the middle adolescent.

Middle adolescents often fall in love for the first time. Again, because they are self-centered, the love object may serve as a mirror and reflect characteristics that the teenager admires, rather than seeing an individual who is loved for him- or herself. Sexual experimentation is common, and many adolescents first have intercourse in middle adolescence.

LATE ADOLESCENCE

Teenagers in this stage are most explicitly moving toward adult roles and responsibilities. Some are beginning full-time jobs; others are beginning families. Many are preparing for these adult roles. The late adolescent completes the process of physical maturation. Many achieve the ability to understand abstract concepts, and they become more aware of their limitations and how their past will affect their future. They understand the consequences of their actions and behaviors, and they grapple with the complexities of identity, values, and ethical principles. Within the family, they move to a more adult relationship with their parents. The peer group recedes in importance as a determinant of behavior, and sexuality may become closely tied to commitment and planning for the future.

TABLE I: HIGHLIGHTS OF ADOLESCENT DEVELOPMENT STAGES

EARLY ADOLESCENCE

Females ages 9-13, Males ages 11-15

- Puberty as hallmark
- Adjusting to pubertal changes such as secondary sexual characteristics
- Concern with body image
- Beginning of separation from family, increased parent-child conflict
- Presence of social group cliques
- Identification in reputation-based groups
- Concentration on relationships with peers
- Concrete thinking but beginning of exploration of new ability to abstract

MIDDLE ADOLESCENCE

Females ages 13-16, Males ages 14-17

- Increased independence from family
- Increased importance of peer group
- Experimentation with relationships and sexual behaviors
- Increased abstract thinking ability

LATE ADOLESCENCE

Females ages 16 and older, Males ages 17 and older

- Autonomy nearly secured
- Body image and gender role definition nearly secured
- Empathetic relationships
- Attainment of abstract thinking
- Defining of adult roles
- Transition to adult roles
- Greater intimacy skills
- Sexual orientation nearly secured

DEVELOPMENTAL TASKS

Developmental psychologists have identified six key developmental tasks for adolescents. The Commission affirms that becoming a sexually healthy adult is embedded in these key developmental tasks. The six key tasks are:

Physical and Sexual Maturation: Adolescents mature biologically into adults, a process that occurs at an earlier chronological age than it did in the past.

Independence: Adolescents develop autonomy within the structure that gave them nurture and support during their childhood. This is usually the family, but may include some similar surrogate structure. The parent-child relationship is transformed during adolescence, as the young person develops autonomy while obtaining the skills to maintain satisfying relationships within the home and with others.

Conceptual Identity: Adolescents establish and place themselves within the religious, cultural, ethnic, moral, and political constructs of their environments.

Functional Identity: Adolescents begin to prepare themselves for adult roles in society. By identifying their competencies, they discover how they will support themselves and contribute to their own families and society.

Cognitive Development: Children and young adolescents are concrete thinkers and focus on real objects, present actions, and immediate benefits. They have difficulty projecting themselves into the future. During adolescence, young people will develop a greater ability to think abstractly, plan for their future, and understand the impact of their current actions on their future lives and other people.

Sexual Self-concept: During adolescence, young people tend to experience their first adultlike erotic feelings, experiment with sexual behaviors, and develop a strong sense of their own gender identity and sexual orientation.

The pursuit of these developmental tasks answers three psychosocial questions that adolescents ask themselves: Am I normal? Am I competent? Am I lovable and loving? (Scales, 1991) Many adolescent behaviors can be attributed to the search for affirmative answers to these questions.

PHYSICAL AND SEXUAL MATURATION

Sexual maturation differs significantly among young men and young women. On average, young girls begin pubertal events one to two years before boys. The adolescent female completes the process of puberty in three to five years, whereas for males, the process takes four to six years.

Although it is beyond the scope of this document to provide in-depth information about physical development, certain key points that relate to adolescent sexuality should be emphasized.

***Young people today are reaching sexual maturity at much younger ages than they did in the past.** Today, most girls experience menarche (first menstruation) between 12-12.5 years of age. Records from family Bibles around the time of the American Revolution indicate an age of menarche of approximately 17 years. In 1860, the average age of menarche was somewhat more than 15 years in Europe and Northern America. During the past century, the age at menarche declined an average of three months per decade until 1960. Over the past three decades, the average age of menarche appears to have remained constant at 12-12.5, with slight ethnic and urban-rural differences in the United States. (Neinstein, 1991)

***Early pubertal development is associated with an increased likelihood for early experimentation with sexual behaviors, in particular intercourse.** Girls and boys who mature early are more likely than others to have had sexual intercourse. (Chilman, 1990; Paikoff and Brooks-Gunn, 1991)

***The discrepancy between maturation among young women and young men is one factor that may contribute to some young women seeking partners older than themselves.** This difference in age places young women at considerable risk for sexual exploitation. (See Box page 19)

***Adjusting to the biological changes of puberty is a major task of early adolescence, and society does not adequately prepare or support young people during these changes.** A significant minority of young women do not receive education about menstruation before menarche, and few adult men can recall receiving information on pubertal maturation prior to their first ejaculation or nocturnal emission. Many adolescents are embarrassed by or ashamed of normal pubertal events.

Sexual health for adolescents includes an ability to appreciate one's own body and to view pubertal changes as normal. Achievement of these goals is dependent on parents' and other trusted adults' preparing young people in advance of pubertal events, as well as supporting them during this important transition.

COGNITIVE DEVELOPMENT

During adolescence, young people develop a range of intellectual characteristics that increase the probability that they will be able to become sexually healthy adults. Ideally, this includes developing the ability to reason abstractly, to foresee consequences of actions, and to understand the social context of behaviors. Adolescents develop an increased ability to control impulsivity, to identify the future implications of their actions, and to obtain control of their future plans.

Decision-making abilities increase during adolescence. Conformity with one's peers peaks in early adolescence. In middle adolescence, people develop the skills to strengthen the capacity for autonomous decision making. They begin to develop a better understanding of personal risks, possible consequences, and the need to obtain more information. (Peterson and Leffert, 1994)

"The future ain't what it used to be."

Teenage male, NY

Developmental age and general level of cognitive and emotional development may influence adolescent sexual decisions and contraceptive use. An adolescent's degree of cognitive maturity may place limits on his or her ability to plan for sexual relationships, clearly articulate personal values, negotiate with a partner, and obtain contraception and condoms. Further, the adolescent's ability to form empathetic relationships is dependent on "social cognition"; being able to see a situation from another person's perspective is one aspect of cognitive development. Understanding one's feelings and the feelings of others is central to emotional growth.

SEXUAL SELF-CONCEPT

Sexual self-concept, an individual's evaluation of his or her sexual feelings and actions, develops during adolescence. Young people develop a stronger sense of gender identity. They understand and more clearly identify as men and women. An understanding of one's sexual orientation also develops during adolescence: Young people become more aware of their sexual attractions and love interests, and adultlike erotic feelings emerge. Sexual experimentation is common among all groups of adolescents, as will be discussed in depth in the section "Adolescent Sexual Behavior in the 1990s."

During adolescence, young people solidify their gender identification by observing the gender roles of their parents and other adults. Gender identification includes understanding that one is male or female and the roles, values, duties, and responsibilities of being a man or a woman. Most young people have a firm sense of their maleness or femaleness prior to adolescence, but in adolescence, clear identification with adult masculine and feminine models emerge. It is essential that adolescents have men and women in their environment who convey the values, behaviors, and attitudes of appropriate gender role models. By interacting with psychologically healthy adult men and women, adolescents learn who they are and how to behave in appropriate ways.

Gender role stereotypes impede both young men and young women in attaining sexual health. Young women may learn that "it is better to be cute and popular than smart," "girls have few sexual feelings," and "girls who carry condoms are bad." Boys may learn that "real men are always ready for sex," and that "guys should never act like girls." One study found that teenage males who agree with traditional cultural messages about masculinity are more likely than other young men to use condoms less consistently (or not at all), and to say that if they made a partner pregnant, they would feel like a "real man"; they are less likely to think men share the responsibility for preventing pregnancy. (Pleck, 1991)

It is important to note that although patterns of sexual involvement are increasingly similar for boys and girls, persistent gender stereotypes mean that young women still experience their sexual behaviors quite differently. (Thompson, 1990) In a 1994 poll, young women reported that they were more likely to regret their sexual experiences, more likely

to label the relationship "love," less likely to report their sexual experiences as pleasurable, and more likely to bear the brunt of negative outcomes than their male counterparts. (Roper, 1994)

One's sexual orientation often emerges in adolescence. In one study of students in grades 7 - 12, 88 percent of teenagers described themselves as predominantly heterosexual, 1 percent described themselves as bisexual or predominantly homosexual, and 11 percent were "unsure" of their sexual orientation. Uncertainty about sexual orientation diminished with chronological age; 26 percent of the twelve-year-olds were "unsure" compared with only 5 percent of the eighteen-year-olds. (Remafedi et al., 1992)

In retrospective studies, many gay and lesbian adults identify adolescence as a period of confusion about their sexual identity. Although a majority of adult gay men recall feeling different as children (Bell, Weinberg, and Hammersmith, 1981), most did not self-identify as gay until their late teenage years. Gay males begin to believe that they might be homosexual at an average age of seventeen years (Troiden, 1980); lesbians at an average of eighteen. Gay males act on their homosexual feelings at a mean age of fifteen years while lesbians report an average age at first genital sexual experience at twenty. (Bell, Weinberg, and Hammersmith, 1981)

"Coming out," or sharing one's sexual orientation with others, generally does not occur until adulthood.

"You expect men to be experienced, it's like a given. We're supposed to be these perfect little flowers and the idea of saving ourselves for our perfect little marriage is expected."

Kelly, H.S. Senior, IN

CHARACTERISTICS OF A SEXUALLY HEALTHY ADOLESCENT

The Commission identified the characteristics and behaviors of a sexually healthy adolescent in relationship to self, parents and other family members, peers, and romantic partners. Sexually healthy adolescents appreciate their bodies, take responsibility for their own behaviors, communicate effectively within their families, communicate effectively with both genders in appropriate and respectful ways, and express love and intimacy in a developmentally appropriate manner. Sexual health is not defined by which sexual behaviors a teenager has or has not engaged in. The Commission recognizes that the majority of attributes and behaviors relevant to self, peers, and partners also apply to a sexually healthy adult and, in many cases, represent an ideal to strive toward.

SELF

APPRECIATES OWN BODY

- Understands pubertal change
- Views pubertal changes as normal
- Practices health-promoting behaviors, such as abstinence from alcohol and other drugs and undergoing regular check-ups.

TAKES RESPONSIBILITY FOR OWN BEHAVIORS

- Identifies own values
- Decides what is personally "right" and acts on these values
- Understands consequences of actions
- Understands that media messages can create unrealistic expectations related to sexuality and intimate relationships
- Is able to distinguish personal desires from that of the peer group
- Understands how alcohol and other drugs can impair decision making
- Recognizes behavior that may be self-destructive and can seek help

IS KNOWLEDGEABLE ABOUT SEXUALITY ISSUES

- Enjoys sexual feelings without necessarily acting upon them
- Understands the consequences of sexual behaviors
- Makes personal decisions about masturbation consistent with personal values
- Makes personal decisions about sexual behaviors with a partner
- Understands own gender identity
- Understands effect of gender role stereotypes and makes choices about appropriate roles for oneself
- Understands own sexual orientation
- Seeks further information about sexuality as needed
- Understands peer and cultural pressure to become sexually involved
- Accepts people with different values and experiences

RELATIONSHIPS WITH PARENTS AND FAMILY MEMBERS

COMMUNICATES EFFECTIVELY WITH FAMILY ABOUT ISSUES, INCLUDING SEXUALITY

- Maintains appropriate balance between family roles and responsibilities and growing need for independence

- Is able to negotiate with family on boundaries
- Respects rights of others
- Demonstrates respect for adults

UNDERSTANDS AND SEEKS INFORMATION ABOUT PARENTS' AND FAMILY'S VALUES, AND CONSIDERS THEM IN DEVELOPING ONE'S OWN VALUES

- Asks questions of parents and other trusted adults about sexual issues
- Can accept trusted adults' guidance about sexuality issues
- Tries to understand parental point of view

PEERS

INTERACTS WITH BOTH GENDERS IN APPROPRIATE AND RESPECTFUL WAYS

- Communicates effectively with friends
- Has friendships with males and females
- Is able to form empathetic relationships
- Is able to identify and avoid exploitative relationships
- Understands and rejects sexually harassing behaviors
- Respects others' rights to privacy
- Respects others' confidences

ACTS ON ONE'S OWN VALUES AND BELIEFS WHEN THEY CONFLICT WITH PEERS

- Understands pressures to be popular and accepted and makes decisions consistent with own values

ROMANTIC PARTNERS

EXPRESSES LOVE AND INTIMACY IN DEVELOPMENTALLY APPROPRIATE WAYS

- Believes that boys and girls have equal rights and responsibilities for love and sexual relationships
- Communicates desire not to engage in sexual behaviors and accepts refusals to engage in sexual behaviors
- Is able to distinguish love and sexual attraction
- Seeks to understand and empathize with partner

HAS THE SKILLS TO EVALUATE READINESS FOR MATURE SEXUAL RELATIONSHIPS

- Talks with a partner about sexual behaviors before they occur
- Is able to communicate and negotiate sexual limits
- Differentiates between low- and high-risk sexual behaviors
- Together with a partner, makes sexual decisions and plans behaviors
- If having intercourse, protects self and partner from unintended pregnancy and diseases through effective use of contraception and condoms and other safer sex practices
- Knows how to use and access the health care system, community agencies, religious institutions, and schools; and seeks advice, information, and services as needed

"I realize how important it is to take care of myself and think hard about the sexual choices I make."

Teenage Female

ADOLESCENT SEXUAL BEHAVIOR IN THE 1990s

Almost all American adolescents engage in some type of sexual behavior. Although policy debates have tended to focus on sexual intercourse and its negative consequences, young people explore dating, relationships, and intimacy from a much wider framework. The information below is presented to give policy makers an accurate picture of adolescent sexual behavior in the 1990s.

Throughout time, adults have viewed adolescent sexuality and the developmental tasks of youth as problematic. Over two thousand years ago, Socrates described youth as disrespectful of their elders: "They are also mannerless and fail to rise when their elders enter the room. They chatter before company, gobble up dainties at the table, cross their legs, and tyrannize over their teachers."

Historically, young women and young men did not reach physical maturity until their middle teenage years. Marriage and other adult responsibilities followed puberty closely.

Today's teenagers are different from young people of generations ago. They reach puberty earlier, have intercourse earlier, and marry later. Women and men who marry today do so three to four years later than young people did in the 1950s.

Sexual behavior is almost universal among American adolescents.

Consider these statistics:

- A majority of American teenagers date.
- 85 percent of American teenagers have had a boyfriend or girlfriend.
- 85-90 percent of American teenagers have kissed someone romantically.
- 79 percent have engaged in "deep kissing." (Coles and Stokes, 1985; Roper, 1994)

The majority of adolescents move from kissing to other more intimate sexual behaviors during their teenage years.

- More than half of all teenagers have engaged in "petting behaviors." By the age of fourteen, more than half of all boys have touched a girl's breasts, and a quarter have touched a girl's vulva. (Coles and Stokes, 1985)
- By the age of eighteen, more than three-quarters have engaged in heavy petting. (Roper, 1994)
- One-quarter to one-half of young people reporting experience with fellatio and/or cunnilingus. (Coles and Stokes, 1985; Newcomer and Udry, 1985)
- 2-5 percent of teenagers report some type of same-gender sexual experience. (Coles and Stokes, 1985; Remafedi, 1992; Roper 1994)

Some data suggest that the progression from kissing to noncoital behaviors to intercourse differs among different groups of adolescents. While many teenagers move through a progression of intimate behaviors, lower-income teenagers are less likely to follow this progression, moving more rapidly from kissing directly to sexual intercourse. (Brooks-Gunn and Furstenberg, 1990)

MOST TEENAGERS WHO HAVE INTERCOURSE DO SO RESPONSIBLY.

More than 80 percent of Americans first have intercourse as teenagers. (AGI, 1994) More than half of women and almost three-quarters of men aged 15-19 have had sexual intercourse. However, despite the large numbers of young people who experiment with a variety of sexual behaviors, intercourse is generally less widespread and certainly less frequent than many teenagers and adults believe. The majority of teenagers use contraceptives as consistently and effectively as most adults.

Teenagers have always engaged in sexual behaviors. However, in the past, at least for teenage women, intercourse was reserved for engaged or married couples. When an out-of-wedlock pregnancy occurred, "shotgun" marriages were frequently the answer, or girls were sent away to stay with a relative until the baby was born and adopted. It may surprise readers to note that the birthrate for adolescents peaked in 1957.

In fact, the adolescent birthrate is significantly lower than it was forty years ago. In 1955, 90 out of every 1,000 15-19-year-old women gave birth; by 1992, that number had dropped to 61 in every 1,000. (Child Trends, 1995)

Nevertheless, in the last two decades, there has been a significant change in the numbers of young people who have had intercourse at young ages. At each age of adolescence, higher proportions of teenage men and women have had sexual intercourse today than had done so twenty years ago. (AGI, 1994)

Contraceptive use has also increased substantially during this time. In 1979, fewer than half of adolescents used a contraceptive at first intercourse (Zelnik and Shah, 1983; Forrest and Singh, 1990); in 1988, two-thirds did so. By 1990, that proportion had increased to more than 70 percent. (National Center for Health Statistics, 1995) Recent surveys suggest that as many as two-thirds of teenagers now use condoms; these proportions are two to three times higher than those reported in the 1970s. (CDC, 1992) However, in every survey, fewer than half of the teenagers who recently used condoms did so all of the time. (Cates, 1991)

Consider these additional facts:

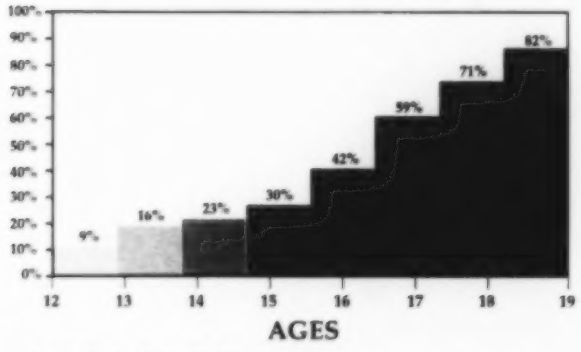
- The majority of teenagers wait until middle and late adolescence to have intercourse. (AGI, 1994; CDC, 1992) (See Table II)
- In the United States, the average age at first intercourse is sixteen for males and seventeen for females. (AGI, 1994; CDC, 1994)
- The majority of teenagers report they do not feel peer or partner pressure to have intercourse. (Roper 1994; Smith 1988)
- The majority of teenagers who have intercourse do so with someone whom they love or seriously date. (Roper, 1994)
- Typically, teenage men and women who have sexual intercourse do so less than once a month. (AGI, 1994; Sonenstein, Pleck, and Icon, 1991)

"Teenagers are portrayed as sex maniacs, when in fact this isn't true. Teens show just as much responsibility or lack of responsibility as adults."
Juan, 17, NY

- The majority of teenagers who have intercourse use contraception. Two-thirds of adolescents use a method the first time they have intercourse (AGI, 1994), and more than three-quarters do so on an ongoing basis. (AGI, 1994) Almost 60 percent used a condom at last intercourse. (CDC, 1994)

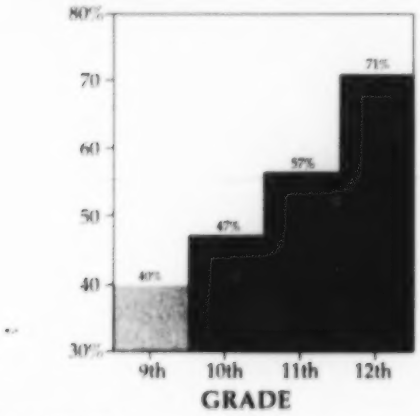
TABLE II

PERCENTAGE OF TEENAGERS WHO HAVE HAD INTERCOURSE, BY AGE



Source: The Alan Guttmacher Institute, 1994

PERCENTAGE OF TEENAGERS WHO HAVE HAD INTERCOURSE, BY GRADE



Source: CDC, 1992

FOR SOME ADOLESCENTS, PARTICULARLY THE YOUNGEST, INTERCOURSE IS DEVELOPMENTALLY DISADVANTAGEOUS.

The Commission affirms that for many adolescents, sexual involvement is pleasurable, safe, and normative. However, for a significant minority of young people, these behaviors can be quite risky and dangerous. In particular, young adolescents who become involved in sexual behaviors prematurely face a host of risks.

Although intercourse is relatively rare for young adolescents, in some population groups, it is quite common. According to a national youth poll, in 1990, 20 percent of females and 34 percent of males have intercourse before they are fifteen. (CDC, 1992)

The Commission believes that intercourse is developmentally disadvantageous for young adolescents as they do not have the cognitive or emotional maturity for involvement in intimate sexual behaviors, especially intercourse. The Commission had a lively debate about whether to recommend a minimum chronological age for intercourse. The Commission agreed by consensus that developmental age and readiness, as well as relationship context, are more important than chronological age.

Consider these facts:

- Teenage sexual behavior, particularly among the youngest teenagers, is often not voluntary, and young people who have been sexually abused often experience delays in cognitive, social, emotional, and psychological development. Further, compared with other adolescents, they have first voluntary intercourse at younger ages, a larger number of partners, and a greater likelihood of adolescent pregnancy and childbearing. (Boyer and Fine, 1992)

- Teenage women have male sexual partners on average three years older than they are. The National Center for Health Statistics reports that in almost 70 percent of births to teenage girls, the fathers were aged 20 or older. (National Center for Health Statistics, 1991) A California study found that the younger the mother, the greater the partner age gap. Among mothers aged 11 and 12, the fathers' age averaged nearly 10 years older. (California Vital Statistics Section, 1992)

- The earlier a teenager begins having intercourse, the more partners she or he is likely to have. Young people whose first intercourse occurred before age thirteen are nine times more likely to report three or more partners than those adolescents whose first sexual intercourse was at fifteen or sixteen. (CDC, 1992) Among fifteen to twenty-four year-olds who had initiated intercourse before age eighteen, 75 percent report having two or more partners, and 45 percent report having had four or more partners. (MMWR, 1992)

SEXUAL ABUSE

Not all adolescent sexual behavior is voluntary. Sexual assault is not uncommon among adolescents. Six percent of boys and fifteen percent of girls are sexually assaulted prior to their sixteenth birthday. In a study of teenage girls in foster care, 43 percent reported experiencing some type of sexual abuse. One in six reported that they had been forced to have intercourse with an adult. One-third of the young women had been sexually abused before their tenth birthday. (Polit, et. al., 1990) Ten thousand young women under age eighteen were raped in 1992. (Child Welfare League, 1994) In fact, one-quarter of rapes are to women 11-17 years of age. (National Victims Center and Crime Victims Research and Treatment Center, 1992) Nearly three-quarters of young women who had intercourse before age fourteen report having had intercourse involuntarily. (AGI, 1994; Child Welfare League of America, 1994)

A disproportionate number of young women who become pregnant during adolescence are victims of childhood sexual abuse. In one study of teenagers who were pregnant or parents, 70 percent of whites, 42 percent of the African-Americans, and 37 percent of Hispanics had been sexually abused as a child. (Boyer and Fine, 1992) In another study, 64 percent of parenting and pregnant teens reported that they had had at least one unwanted sexual experience. (Child Welfare League of America, 1994)

Gay, lesbian, and bisexual teenagers face an additional form of abuse related to their sexuality. A study in New York City found that of lesbian, gay and bisexual teenagers reporting an assault, almost half reported the assault was related to their sexual orientation, and for almost two-thirds, the assault happened within their families. (Hunter, 1990)

"People are talking to us after it's already too late."

Melisa, 14, IN

ABSTINENCE AND SEXUAL INTERCOURSE

The Commission believes that too much of the public policy debate about adolescent sexuality has focused on whether adolescents should abstain from sexual behaviors, particularly intercourse, or whether contraception and condoms should be available. Some sexually healthy adolescents abstain from intercourse; some sexually healthy adolescents have intercourse.

The Commission affirms the following:

Society should encourage adolescents to delay sexual behaviors until they are ready physically, cognitively, and emotionally for mature sexual relationships and their consequences. This support should include education about intimacy; sexual limit setting; resisting social, media, peer, and partner pressure; benefits of abstinence from intercourse; and pregnancy and STD prevention.

The Commission urges all adult sectors of society (parents, schools, religious institutions, community youth programs, media, and government) to give adolescents consistent and age-appropriate messages about abstinence.

All messages should clearly communicate to teenagers that abstinence from sexual intercourse is the most effective method of preventing pregnancies and sexually transmitted diseases. The Commission affirms that delaying first intercourse until late adolescence is likely to result in lower rates of pregnancy, STDs, and childbearing.

The Commission opposes education programs that are designed to provoke fear and shame in adolescents about sexuality in order to enforce abstinence from all sexual behaviors. The Commission believes that young adolescents in particular need clear messages on the benefits of abstinence, but that programs must also address the likelihood that many young people will have intimate sexual relationships.

The Commission recommends that messages about abstinence include the following:

- Young adolescents are not mature enough for a sexual relationship that includes intercourse.
- Most young adolescents do not have intercourse.
- Teenagers who date need to discuss sexual limits with their romantic partner.
- People need to respect the sexual limits set by their partners.
- There are many ways to give and receive sexual pleasure and not have intercourse.
- Teenagers considering sexual intercourse should talk to a parent or other trusted adult.
- Most adults believe teenagers should not have sexual intercourse.
- Many religions believe that sexual intercourse should occur only in marriage.
- Abstinence from intercourse has benefits for teenagers.

The Commission recommends that messages about abstinence for older adolescents also include the following:

- Many teenagers in the United States have had sexual intercourse and many have not.
- Sexual intercourse is not a way to achieve adulthood.
- People in romantic relationships can express their sexual feelings without engaging in sexual intercourse.
- Many adults experience periods of abstinence.

The Commission also affirms the following:

Society must also recognize that a majority of adolescents will become involved in sexual relationships during their teenage years. Adolescents should receive support and education for developing the skills to evaluate their readiness for mature sexual relationships. Responsible adolescent intimate relationships, like those of adults, should be based on shared personal values, and should be consensual, non-exploitative, honest, pleasurable, and protected against unintended pregnancies and sexually transmitted diseases, if any type of intercourse occurs.

The Commission adapted the following checklist to help young people assess their readiness for mature sexual relationships. (Winship, 1983)

This checklist may be helpful for adolescents and adults to evaluate if they are ready for a mature sexual relationship with a partner. Ideally, these criteria would be met before a young person or an adult engages in intimate sexual behaviors, including any type of intercourse.

READINESS FOR MATURE SEXUAL RELATIONSHIPS

PERSONAL CHARACTERISTICS

Each individual is:

- ☐ Physically mature
- ☐ Patient and understanding
- ☐ Knowledgeable about sexuality and sexual response
- ☐ Empathetic and able to be vulnerable
- ☐ Committed to preventing unintended pregnancies and STDs
- ☐ Able to handle responsibility for positive consequences
- ☐ Able to handle responsibility for potential negative consequences
- ☐ Honestly approving of the behavior

RELATIONSHIP CHARACTERISTICS

- ☐ The relationship is committed, mutually kind, and understanding.
- ☐ Partners trust and admire each other.
- ☐ Partners have experimented and found pleasure in non-penetrative behaviors.
- ☐ Partners have talked about sexual behaviors before they occur.
- ☐ Motivation for sexual relationship is pleasure and intimacy.
- ☐ The setting for the sexual relationship is safe and comfortable.

"They have questions. They need to have those questions answered honestly and directly, not with, 'Wait till you're married kid'."
Meghan, H.S., IN

AN INTERNATIONAL COMPARISON

Young people around the world experiment with sexual behaviors. Young people in Northern European countries and the United States have similar ages at first intercourse, but Northern European teenagers have much lower pregnancy and STD rates. European countries tend to be more open about sexuality, and their official governmental policies focus on reducing unprotected intercourse, rather than reducing sexual behaviors. There is a greater availability of sexual information and reproductive health services for teenagers.

The United States has one of the highest adolescent birthrates in the world. Teenagers in Sweden, the Netherlands, Canada, Great Britain, France, and the United States experience similar levels of sexual intercourse, but teenagers in other countries are much more successful than U.S. adolescents at avoiding sexual morbidities. For example, Sweden has one-third and the Netherlands has one-sixth the U.S. rate of teenage pregnancies, despite similar levels of teenage sexual intercourse. A 1985 study of thirty-seven industrialized countries found that a major reason for the difference is that European teenagers use contraception effectively. (Jones, et al., 1988)

According to the study's authors:

- Teenagers in these countries are not too immature to use contraceptives consistently and effectively.
- Teenage pregnancy rates are lower in countries where there is greater availability of confidential contraceptive services and comprehensive sexuality education. (Jones, et. al., 1988)

THE ADULT ROLE IN PROMOTING ADOLESCENT SEXUAL HEALTH

Many adults have difficulty acknowledging teenagers' emerging sexuality. Adults' denial and disapproval of teenage sexual behavior may actually increase teenagers' risk of pregnancy and sexually transmitted diseases. The majority of adults disapprove of teenagers having intimate sexual relationships, and adolescents often perceive this disapproval. Many teenagers are willing to risk pregnancy and disease rather than damage their "reputation" with their parents or experience the disapproval of adults with whom they must interact to obtain contraceptives and condoms.

The Commission urges policy makers to remember that adolescents grow up in families and communities, and that these communities must be involved in promoting adolescent sexual health. The Commission affirms that all sectors of the community--parents, families, schools, community agencies, religious institutions, media, businesses, health care providers, and government at all levels--have important roles to play.

PARENTS

Parents are the primary sexuality educators of their children. They educate both by what they say and by how they behave. It is important to begin deliberate education at the earliest childhood level; however, adolescence poses new challenges for many parents. In homes where there is open communication about contraception and sexuality, young people often behave more responsibly. At a minimum, such communication may help young people accept their own sexual feelings and actions. With open communication, young people are more likely to turn to their parents in times of trouble; without it, they will not. (Blum, Resnick, and Stark, 1987)

Many parents have difficulty communicating with their children about sexuality. Parents must receive education about sexuality and how to provide this education and information to their children.

Individual adults, especially parents and other trusted adult family members, can play an important role in encouraging adolescent sexual health. Adults can assure that young people have access to accurate information and education about sexuality issues by direct communication and by providing books, pamphlets, and videos. Adults need to foster responsible sexual decision-making skills and need to model healthy sexual attitudes and responsible behaviors in their own lives.

The Commission believes that parents and families can play a major role in ensuring adolescent sexual health. The Commission developed the following list of behaviors that often characterize the parents of a sexually healthy adolescent.

These parents:

- Demonstrate value, respect, acceptance and trust in their adolescent children
- Model sexually healthy attitudes in their own relationships
- Maintain nonpunitive stance toward sexuality
- Are knowledgeable about sexuality
- Discuss sexuality with their children
- Provide information on sexuality to their children

"I think our parents are trying to do a better job than their parents did when it comes to talking to their children."

H.S. Student, Colorado

- Seek appropriate guidance and information as needed
- Try to understand their adolescent's point of view
- Help adolescents gain understanding of values
- Set and maintain limits for dating and other activities outside of school
- Stay actively involved in the young person's life
- Ask questions about friends and romantic partners
- Provide a supportive and safe environment for their children
- Offer to assist adolescents in accessing health care services
- Help them plan for their future

COMPREHENSIVE SEXUALITY EDUCATION

The Commission affirms that children and youth need age-appropriate comprehensive sexuality education. Further, the Commission recognizes that schools are only one site for sexuality education. Community agencies, religious institutions and youth serving organizations should develop sexuality education programs that are appropriate for their settings. In addition, education programs should be available for parents of children and adolescents to help them provide sexuality education within their homes.

The primary goal of sexuality education is the promotion of sexual health. Comprehensive sexuality education seeks to assist children in understanding a positive view of sexuality, to provide them with information and skills about taking care of their sexual health, and to help them acquire skills to make decisions now and in the future. A comprehensive sexuality education program includes information as well as an opportunity to explore attitudes and develop skills in such areas as human development, relationships, personal skills, sexual behavior, sexual health, and society and culture. (National Guidelines Task Force, 1991)

The characteristics of effective comprehensive sexuality education programs include the following:

- Are experiential and skill-based;
- Are taught by well-trained teachers and leaders;
- Discuss controversial issues;
- Provide multiple sessions through multiple mediums;
- Are relevant to all teenagers, regardless of sexual orientation;
- Are culturally specific and sensitive;
- Are linguistically appropriate;
- Discuss social influences and pressures;
- Reinforce values and group norms against unprotected sexual behaviors;
- Provide age- and experience-appropriate messages and lessons;
- Teach skill-building, including refusal skills;
- Are integrated within comprehensive health education; and
- Use peer counseling and peer support when appropriate.

HEALTH CARE

The Commission affirms the need for health providers, health care organizations, and communities to provide

young people with affordable, sensitive, and confidential sexual and reproductive health care services. This includes mental health counseling; support services for gay and lesbian youth; family planning; abortion; STD screening, diagnosis, and treatment; and prenatal care.

School-based and school-linked programs, special adolescent health care services, and private practitioners all have special roles to play in reaching adolescents with these important services. It is also important that there be formal linkages between health care delivery and education programs.

The characteristics of effective health and medical programs for adolescents include the following:

- All staff have both an interest and special training in working with adolescents.
- The operating hours and location are convenient for teenagers.
- The physical space is inviting to adolescents.
- Counseling is a routine part of each visit.
- Confidentiality is assured.
- Parental involvement is encouraged.
- The staff include the teen's family when appropriate and negotiate the balance between confidentiality and adult support and involvement.
- The approach is multidisciplinary.
- There is a focus on sexuality and sexual health.
- Services are affordable to teenagers.
- Youth are involved in designing and implementing the program.
- Continuity from pediatric care to adult care is assured.
- Bilingual and bicultural staff are available, as needed.

COMMUNITY PROGRAMS

Community youth-serving programs can play a major role in ensuring adolescent sexual health. The Commission urges such programs--including girls' and boys' clubs, scouts, sports organizations, public libraries, recreation departments, after-school programs, worksites, camps, juvenile justice centers, job training programs, and religious organizations--to develop sexuality education programs as well as a variety of opportunities to provide young people with education and employment opportunities. (Carnegie Corporation of New York, 1992)

Community programs should work together to give young people a consistent set of messages regarding community values about such issues as sexual behaviors, responsibility, and future planning. Programs should reinforce each other.

The characteristics of effective community programs include the following:

- They are accessible to young people.
- The setting is safe and inviting.
- The program offers adolescents opportunities to contribute to the community and feel competent.
- Mentoring programs are featured.

"Not everybody has parents they can talk to. Where are those kids supposed to go? You've got to think about everybody."
Nicole, H.S. Senior, WI

- Staff integrate sexuality information and referrals into other youth development programs.
- They offer an opportunity to develop relationships with both genders.
- They are run by well-trained leaders.
- They have an established referral network for health care services.
- They encourage family involvement.
- They are culturally specific and sensitive, and linguistically appropriate.

MASS MEDIA

The Commission recognizes that the mass media have become a major source of young people's information about sexuality. The Commission urges those who work in the mass media to exercise their influence by providing accurate information and modeling responsible behaviors. The communication of accurate information adds realism and helps adolescents gain insights into their own sexuality, and to make more responsible decisions about their behavior.

The Commission strongly encourages writers, producers, programming executives, reporters, and others to incorporate the following into their work whenever possible:

- Provide diverse and positive views of a range of body images and eliminate stereotypes about sexuality and sexual behaviors; for example, eliminating the ideas that only beautiful people have sexual relationships or that all adolescents have intercourse.
- When describing or portraying a sexual encounter, include steps that should be taken such as using a condom to prevent unwanted pregnancy and sexually transmitted diseases. Recognize and show that the majority of sexual encounters are planned events, not spur-of-the-moment responses to the heat of passion. Model communication about an upcoming sexual encounter. If the sexual encounter includes unprotected intercourse, portray or refer to the possible short- and long-term negative consequences.
- Although the Commission recognizes the need for dramatic tension and conflict in some relationships, and for the accurate portrayal of stressful relationships when they exist, typical interactions between men and women or boys and girls should be respectful and non-exploitative.
- When possible and appropriate, include information about or the portrayal of effective parent-child communication about sexuality and relationships.
- Lift barriers to contraceptive and condom product advertising.
- When feasible, promote responsible adolescent behavior by using teenage idols to model appropriate actions, highlighting youth success stories, and involving articulate youth spokespersons.
- When possible and appropriate, provide ways for young people to obtain additional information about sexuality and related issues, such as by listing addresses and telephone numbers of appropriate public health organizations and support groups.

SUMMARY OF RECOMMENDATIONS FOR POLICY MAKERS

The National Commission on Adolescent Sexual Health urges policy makers to:

1. Form public policies consistent with research about adolescent development, adolescent sexuality, and program effectiveness.

2. Support parents and families as integral members of efforts to improve adolescent sexual health, while recognizing that adolescents are developing greater autonomy.

3. Recognize that sexual development is an essential part of adolescence and that the majority of adolescents engage in sexual behaviors as part of their overall development.

4. Facilitate optimal adolescent development by ensuring high-quality education and employment opportunities for all young people.

5. Support comprehensive sexuality education, which includes human development, relationships, personal skills, sexual behavior, sexual health, and sexuality and culture.

6. Provide a full range of confidential sexual and reproductive health services tailored for the adolescent.

7. Encourage cultural messages that support adolescent and adult sexual health and responsible sexual relationships.

8. Support research on adolescent sexuality and sexual behaviors.

9. Provide funding for coordinated and integrated adolescent programs.

10. Respond to the diverse sexual health needs of adolescents, including addressing the needs of disenfranchised, disabled, and gay and lesbian adolescents.

11. Involve youth in program planning and implementation.

12. Value and respect adolescents.

ADDITIONAL READINGS

Adolescent Health: State of the Nation. Atlanta: Centers for Disease Control, 1995.

AIDS Sexual Behavior and Intravenous Drug Use. Washington, DC: National Academy Press, 1989.

A Matter of Time: Risk and Opportunity In The Out-Of-School Hours. New York: Carnegie Corporation of New York, 1992.

Brindis, C. D. **Adolescent Pregnancy Prevention: A Guidebook For Communities.** Palo Alto, CA: Health Promotion Resource Center, Stanford Center for Research in Disease Prevention, 1991.

Dryfoos, J. **Adolescents At Risk.** New York: Oxford University Press, 1990.

Greydanus D. E. (ed): **Caring for Your Adolescent: Ages 12-21.** New York: Bantam Books Inc., 1992.

Guidelines for Comprehensive Sexuality Education. New York: SIECUS, 1991.

Herdt, G. (ed.) **Gay and Lesbian Youth.** New York: The Haworth Press, 1989.

Jones, E. F., et al. **Teenage Pregnancy in Industrialized Countries.** New Haven: Yale University Press, 1986.

Hayes, C. D. **Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing.** Washington: National Academy Press, 1987.

Millstein S., Petersen, A., and Nightingale, E. **Promoting The Health of Adolescents.** New York: Oxford University Press, 1993.

Lawson, A. and Rhode, D. L. (eds). **The Politics of Pregnancy: Adolescent Sexuality and Public Policy.** New Haven: Yale University Press, 1993.

Sex and America's Teenagers. New York: The Alan Guttmacher Institute, 1994.

COMMISSIONERS' BIOGRAPHICAL SKETCHES

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Dr. Beresin teaches on such topics as education and training, eating disorders, personality disorders, and child and adolescent development at Harvard Medical School, Massachusetts General Hospital, and McLean Hospital. He received recognition in 1991 as Teacher of the Year in the child and adolescent residency program at Massachusetts General Hospital, and was awarded the Region I Teacher of the Year from the Association for Academic Psychiatry. Articles by Dr. Beresin have appeared in the *American Journal of Psychotherapy* and *Academic Medicine*, and he has contributed chapters to numerous book projects. Dr. Beresin serves as co-chair of the Training Committee of the American Academy of Child and Adolescent Psychiatry, and chair of the Task Force on Recruitment for the American Academy of Child and Adolescent Psychiatry. He is the president-elect of the New England Council of Child and Adolescent Psychiatry.

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Dr. Blum serves on the board of directors and scientific advisory board of The Alan Guttmacher Institute. He is past president of the Society for Adolescent Medicine and received the Society's 1993 Outstanding Achievement Award. In addition, Dr. Blum has served on a multitude of editorial boards, peer review committees, and federal grant review committees. He has published over 125 articles, books, and chapters, focusing mainly on sexual decision making and pregnancy outcomes among adolescents. Dr. Blum has consulted for the World Health Organization and the Pan American Health Organization, and has made innumerable presentations to national and international organizations.

Michael A. Carrera, Ed.D.
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Dr. Carrera is Thomas Hunter Professor Emeritus of Health Sciences at Hunter College of the City University of New York. He directs both the National Adolescent Sexuality Training Center and the Adolescent Sexuality and Pregnancy Prevention Programs of the Children's Aid Society. Dr. Carrera has authored *Sex: The Facts, The Acts and Your Feelings*, *Sexual Health for Men: Your A to Z Guide*, *Sexual Health for Women: Your A to Z Guide*, and, most recently, *The Language of Sex*. Dr. Carrera has received awards from the American Association of Sex Educators, Counselors, and Therapists (AASECT); Rutgers University; Advocates for Youth; and the Society for the Scientific Study of Sex. He has served as board president for both the Sexuality Information and Education Council of the United States and AASECT.

Arthur B. Elster, M.D.
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Dr. Elster has written extensively on adolescent health promotion and prevention services in such publications as *Pediatrics*, the *Journal of Pediatrics*, and the *American Journal of Diseases of Children*. He has authored books and book chapters, and done extensive public speaking on issues related to adolescent pregnancy and parenthood and adolescent clinical preventive services.

Jacqueline Darroch Forrest, Ph.D.
Senior Vice President and Vice President for Research, The Alan Guttmacher Institute

Dr. Forrest has authored or coauthored over 100 articles and publications on sexual behavior, fertility, family planning, maternal and child health, teenage pregnancy, and abortion. Most recently, she coauthored *Sex and America's Teenagers*, an examination of the myths surrounding the sexual and reproductive behavior of U.S. teenagers. With colleagues at the Institute, she has also recently conducted an investigation of the health benefits and risks of contraception, evaluating effects on fertility, and analyzing women's sexual and reproductive behavior and risk of sexually transmitted diseases. She serves on numerous panels and boards, including the Program Development Board of the American Public Health Association and the Technical Advisory Committee of the Contraceptive Research and Development program (CONRAD).

Donald E. Greydanus, M.D.
Adolescent Health Section, American Academy of Pediatrics

Dr. Greydanus serves on the American Academy of Pediatrics Committee on Scientific Meetings, the Academy's Committee on Adolescence, and the National Medical Committee of the Planned Parenthood Federation of America. Dr. Greydanus serves in an editorial capacity for the *Adolescent Health Section Newsletter* and *Adolescent Medicine: State of the Art Reviews*, and has published over 140 articles, chapters and books in adolescent health. He is the 1995 recipient of the Adele Dellenbaugh Hofmann Award from the American Academy of Pediatrics for excellence in the field of adolescent medicine. Dr. Greydanus is professor of pediatrics and human development at Michigan State University's College of Human Medicine.

Debra W. Haffner, M.P.H.
President, Sexuality Information and Education Council of the United States (SIECUS)

As one of the nation's leading experts on sexuality and HIV / AIDS prevention education, Ms. Haffner has authored articles in a variety of publications, such as *Family Planning Perspectives*, the *Journal of School Health*, the *School Administrator* and newsletters of many national organizations. She has offered keynote presentations and workshops at the annual meetings of diverse national organizations, has provided training in sexuality education to over 13,000 professionals, and has presented to more than 30,000 professionals. She serves on the board of directors of the National Leadership Coalition on AIDS, the National Committee for Responsive Philanthropy, and the Center for Sexuality and Religion and is the past chair of the Family Planning and Population Section Council of the American Public Health Association. She is the recipient of the 1994 Public Service Award of the Society for the Scientific Study of Sex.

Karen Hein, M.D.
Executive Officer, Institute of Medicine, National Academy of Sciences

Dr. Hein is clinical professor of pediatrics, epidemiology, and social medicine at Albert Einstein College of Medicine. At the Institute of Medicine, she oversees eight Divisions responsible for the production of sixty reports each year in a variety of healthy policy issues. Dr. Hein has been the principal investigator on over twenty grants, was the founder and director of the nation's first Adolescent AIDS Program (1987-93) and was the President of the Society for Adolescent Medicine in 1993. She has served on numerous boards and advisory panels, and is a frequent consultant and lecturer in issues related to health care reform, youth and HIV. Dr. Hein has written over 150 manuscripts and is on editorial boards of several journals. She worked in the U.S. Senate Finance Committee on Health Care Reform (1993-1994).

Robert L. Johnson, M.D.
Commission Chair
Director of Adolescent and Young Adult Medicine, University of Medicine and Dentistry, New Jersey Medical School

Dr. Johnson is professor of clinical pediatrics and clinical psychiatry, and director of adolescent and young adult medicine at the New Jersey Medical School. He is associated with local, state, and national organizations, such as the American Academy of Pediatrics, the Society for Adolescent Medicine, and the Governor's Task Force on Adolescent Pregnancy. In addition, he has served on the board of directors of Advocates for Youth, the Children's Defense Fund, and the Sexuality Information and Education Council of the United States (SIECUS). He addresses many national and international audiences each year, and frequently is interviewed for television and radio. Dr. Johnson has published widely, and conducts research and a clinical practice at the New Jersey Medical School.

Mariana Kastrinakis, M.D., M.P.H.
Senior Advisor on Adolescent Health, U.S. Public Health Service, Department of Health and Human Services

Dr. Kastrinakis is an internist who specializes in adolescent medicine. For the past two years, she has been with the Department of Health and Human Services, working on special assignments in adolescent health policy. She is an assistant clinical professor of internal and adolescent medicine at the George Washington University Medical School. In addition, she has given multiple presentations and has been involved in research and publishing in her field of expertise.

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Douglas B. Kirby, Ph.D.
Director of Research, ETR Associates

Dr. Kirby conducts a variety of studies designed to reduce unprotected intercourse among adolescents. He has directed nationwide studies of adolescent sexual behavior, sexuality education programs, and school-based clinics. Dr. Kirby has coauthored research on the *Reducing the Risk* curriculum and published syntheses of other research studies. He has authored numerous volumes, articles, and chapters both on school-based programs to reduce unprotected sexual intercourse and on methods of evaluating these programs. Dr. Kirby has frequently presented on these topics and provided consultation to many groups designing and evaluating programs for youth.

Lawrence A. Kutner, Ph.D.
Psychologist and Journalist

Dr. Kutner is a clinical psychologist and journalist who specializes in issues related to child development and parenting. He is a contributing editor of *Parents* magazine and the author of its "Ask The Expert" column. From 1987 through 1994, he wrote the award-winning, weekly *New York Times* "Parent & Child" column, which also appeared in several hundred newspapers across the United States and Canada. Dr. Kutner is on the faculty of the department of psychiatry at Harvard Medical School, and is the author of four books on child development.

Marilyn Poland Laken, Ph.D., R.N.
Professor of Obstetrics and Gynecology, Division of Community Health Programs, Wayne State University School of Medicine

Dr. Laken received her doctorate in biological anthropology. She has conducted research in and published on issues related to health delivery for vulnerable populations of low-income women, adolescents, and children. She is professor of obstetrics and gynecology at Wayne State University School of Medicine, teaching courses in maternal and child health and alternative medicine. Dr. Laken has reviewed grants for the National Institute of Child Health and Human Development and the Office of Population Affairs. She frequently gives presentations to professional audiences and elected officials, and she serves on state and national advisory groups that direct new programs and policies for women and children.

Carlos W. Molina, Ph.D.
Associate Professor of Public Health Education, York College, City University of New York

Dr. Molina is a former acting vice president for academic affairs at the City University of New York, and former chief executive officer for Lincoln Medical and Mental Health Center in the Bronx, New York. Dr. Molina has served as a member of the American Public Health Association's executive board, as well as on the board of directors of the Planned Parenthood Federation of America and The Alan Guttmacher Institute. He has also served on advisory committees for the Robert Wood Johnson Foundation, the surgeon general's office, and the American Cancer Society. Dr. Molina has published research, presented papers, served on panels, and participated in national press conferences focusing on Latino health concerns.

Rhonda R. Nichols, M.D.
Director of Medical Education, Jersey City Medical Center

Dr. Nichols is a board-certified obstetrician and gynecologist serving as director of medical education in the department of obstetrics and gynecology at Jersey City Medical Center, as well as being in private practice. Dr. Nichols is a former assistant professor of obstetrics and gynecology at the University of Medicine and Dentistry of New Jersey (UMDNJ), where she was the medical director of maternity and infant care in the hospital-based, state-funded Comprehensive Adolescent Pregnancy Program, and administrative director of the Healthy Mothers-Healthy Babies Outreach Team. She is also former director of the pediatric and adolescent gynecologic division at UMDNJ.

Rt. Rev. David E. Richards
Board of Directors, Sexuality Information and Education Council of the United States (SIECUS)

Bishop Richards has served in the ministry of the Episcopal Church since 1945; he has been the bishop of Central America and was the first director of the denomination's Office of Pastoral Development. Bishop Richards has provided training conferences in Africa, Hong Kong, the Philippines, and the West Indies. He was a senior fellow at the Harvard Medical School in 1973-74, and received additional training at the Family Center of Georgetown Medical School. Bishop Richards is associated with Counseling Services in Coral Gables, Florida, and is a co-founder of the Center for Sexuality and Religion.

Peter C. Scales, Ph.D.
Director of National Initiatives, Center for Early Adolescence, School of Medicine, University of North Carolina at Chapel Hill

Before serving as the director of national initiatives at the Center for Early Adolescence, Dr. Scales was chair of the Alaska Governor's Commission on Children and Youth, national director of education for the Planned Parenthood Federation of America, and a senior social scientist for Mathtech. At Mathtech, he coauthored *An Analysis of U.S. Sexuality Education Programs and Evaluation Methods*. He has authored or coauthored more than 140 books and articles, including *A Portrait of Young Adolescents in the 1990's*, *The Front Lines of Sexuality Education*, and *The Sexual Adolescent: Communicating with Teenagers About Sex*. He received the 1988 U.S. Administration for Children, Youth, and Families' Commissioner Award for exceptional service to youth, and was a consultant for the 1992 PBS television program *What Kids Want to Know About Sex and Growing Up*.

Pepper J. Schwartz, Ph.D.
Professor of Sociology, University of Washington

Dr. Schwartz is past president of the Society for the Scientific Study of Sex. She coauthored *A Student's Guide To Sex On Campus*, *American Couples*, and *Peer Marriage*, and has written numerous academic articles. She writes columns on human sexuality for *American Baby* and *Glamour*, and contributes to the *New York Times* "Parent & Child" column. Dr. Schwartz has served on the board of directors of Planned Parenthood of Seattle-King County and the AIDS Foundation.

Isabel C. Stewart, M.Ed.
National Executive Director, Girls Incorporated

Ms. Stewart began with Girls Incorporated as the deputy director in 1991. She had previously served as director for program administration at the National Academy Foundation. Ms. Stewart has been an educator and administrator at the Brearley School in New York, the Trinity School in Atlanta, the American University in Cairo, the William Penn High School in Philadelphia, and the African-American Institute in New York. Ms. Stewart serves on the board of directors at the Brearley School, and has been a member of the board of directors for Hampshire College, the Lower East Side Tenement Museum, and the Mary Reynolds Babcock Foundation.

Ruby Takanishi, Ph.D.
Executive Director, Carnegie Council on Adolescent Development

Dr. Takanishi was the former director of the Office of Scientific Affairs at the American Psychological Association (APA), and administrative officer for children, youth, and family policy at the APA. Dr. Takanishi's extensive background in child development and social policy has informed her work as a professor, consultant, and member of national advisory councils and review panels. Dr. Takanishi has written articles and reviews in such publications as *American Psychologist*, the *Journal of the American Medical Association*, and the *Teachers College Record*. She has received professional honors from the APA and the National Academy of Education.

Elizabeth C. Winship
Author, "Ask Beth"

Ms. Winship is a longtime columnist for the *Boston Globe* and the *L.A. Times* syndicate, providing advice to teenagers on a wide range of sexual health issues. Ms. Winship has written *Ask Beth: You Can't Ask Your Mother*, *Reaching Your Teenager*, and a high school sexuality education textbook, *Perspectives on Health: Human Sexuality*. Ms. Winship received the 1978 Massachusetts Psychological Association Humanitarian Award, and was named the Massachusetts Association of School Psychologists Journalist of the Year in 1982.

REFERENCES

Bell, A. and Weinberg, M. *Sexual Preference: Its Development in Men and Women.* (Indiana: Indiana University Press, 1981).

Blum, R., Resnick, M., and Stark, T., "The Impact of a Parental Notification Law on Adolescent Abortion Decision Making," *American Journal of Public Health,* 77:5 (1987):619-20.

Boyer, D. and Fine, D., "Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment," *Family Planning Perspectives,* 24:1 (1992):4-11.

Brooks-Gunn, J. and Furstenberg, FF, "Coming of Age in the Era of AIDS; Puberty, Sexuality, and Contraception," *The Millbank Quarterly,* 68. Suppl. 1, (1990).

California Vital Statistics Section, "California Resident Live Births, 1990, by Age of Father, by Age of Mother," Sacramento, California: California Vital Statistics Section, Department of Health Services, 1992.

Carnegie Corporation of New York. *A Matter of Time: Risk and Opportunity In The Out-Of-School Hours.* (NY: Carnegie Corporation Of New York, 1992).

Carrera, M. *Sex, The Facts, The Acts, and Your Feelings.* (New York: Crown Publishers, 1981).

Cates, W., "Teenagers and Sexual Risk Taking: The Best of Times and the Worst of Times," *Journal of Adolescent Health,* 12: 2 (1991): 84-94.

Centers for Disease Control and Prevention, "Selected Behaviors that Increase Risk for HIV Infection Among High School Students," *MMWR,* 41 (1992):237.

Centers for Disease Control and Prevention, "Sexual Behavior Among High School Students. United States, 1990," *MMWR,* 40 (1992):886.

Centers for Disease Control and Prevention. *Pregnancy, Sexually Transmitted Diseases, and Related Risk Behaviors Among US Adolescents.* (Atlanta: CDC, 1994).

Child Welfare League of America. *A Survey of 17 Florence Crittenton Agencies Serving Minor Mothers.* (Washington, DC: CWLA, 1994).

Chilman, C., "Family Life Education: Promoting Healthy Adolescent Sexuality," *Family Relations,* 39:2 (1990):123-31.

Child Trends. *Facts At A Glance.* (DC: Child Trends, 1995).

Coles, R. and Stokes, F. *Sex and the American Teenager* (New York: Harper and Row, 1985).

Durant, R., Jay S., and Seymore, C., "Contraceptive and Sexual Behavior of Black Female Adolescents: A Test of a Social-Psychological Theoretical Model," *Journal of Adolescent Health Care,* 11:4 (1990):326-34.

Durban, M., DiClemente, R., and Siegel, D., "Factors Associated with Multiple Sex Partners Among Junior High School Students," *Journal of Adolescent Health,* 14:3 (1993):202-7.

Forrest, J. and Singh, S., "The Sexual and Reproductive Behavior of American Women, 1982-1988," *Family Planning Perspectives,* 22:5 (1990):206-14.

Hunter, J., "Violence Against Lesbian and Gay Male Youths," *Journal of Interpersonal Violence,* 5 (1990):295-300.

Irvine, J. *Sexual Cultures and The Construction of Adolescent Identities.* (PA: Temple University Press, 1994).

Jones, E., et al., "Teenage Pregnancy in Developed Countries: Determinants and Policy Implications," *Family Planning Perspectives,* 17:2 (1985):53-63.

Jones, E., et al., "Unintended Pregnancy, Contraceptive Practice and Family Planning Services in Developed Countries," *Family Planning Perspectives,* 20:2 (1988):53-67.

National Center for Health Statistics, "Contraceptive Use in the United States: 1982-1990," *Advance Data*. February 14, 1995.

National Guidelines Task Force. *Guidelines for Comprehensive Sexuality Education: Kindergarten - 12th Grade*. (New York: Sexuality Information and Education Council of the United States, 1991).

National Victims Center. *Rape In America*. (Virginia: National Victims Center, 1992).

Neinstein, L.S. *Adolescent Health Care: A Practical Guide*. (Maryland: Urban and Schwarzenberg, Inc., 1991).

Newcomer, S. and Udry, J., "Oral Sex in An Adolescent Population." *Archives of Sexual Behavior*, 14 (1985): 41-46.

Paikoff, R. and Brooks-Gunn, J., "Do Parent-Child Relationships Change During Puberty?," *Psychological Bulletin*, 110 (1991):47-66.

Peterson, A.C. and Leffert, N., "What is Special About Adolescence" in Rutter, M., editor, *Psychosocial Disturbances In Young People: Challenges for Prevention*. (Cambridge: Cambridge University Press, 1994).

Pleck, J., Sonenstein, F., and Ku, L., "Masculinity Ideology: Its Impact on Adolescent Males' Heterosexual Relationships." *Journal of Social Issues*, 49:3 (1993): 11-30.

Polit, D., Cozette, W., and Thomas, D., "Child Sexual Abuse and Premarital Intercourse Among High Risk Adolescents," *Journal of Adolescent Health Care*, 11 (1990): 231-34.

Quadrel, M.J., Fischoff, B., and Doris, W., "Adolescent (In)Vulnerability," *American Psychologist*, 48:2 (1993): 102-16.

Remafedi G., et al, "Demography of Sexual Orientation In Adolescents," *Pediatrics*, 89:4 (1992): 714-21.

Roper Starch Worldwide. *Teens Talk About Sex: Adolescent Sexuality in the 90's* (New York: Sexuality Information and Education Council of the United States, 1994).

Scales, P. *A Portrait of Young Adolescents in the 1990's: Implications for Healthy Growth and Development*. (North Carolina: Center for Early Adolescence, University of North Carolina at Chapel Hill, 1991).

Selverstone, R., "Adolescent Sexuality: Developing Self Esteem and Mastering Developmental Tasks," *SIECUS Report*, 18:1 (1989): 1-5.

Smith, P., *National Adolescent Student Health Survey Results* (Reston, VA: American School Health Association, 1988).

Sonenstein, F., Pleck, J., and Ku, L., "Sexual Activity, Condom Use, and AIDS Awareness Among Adolescent Males," *Family Planning Perspectives*, 21:4 (1989): 152-58.

Sonenstein, F., Pleck J., and Ku, L. "Levels of Sexual Activity Among Adolescent Males In The United States," *Family Planning Perspectives*, 23:4 (1991): 162-67.

The Alan Guttmacher Institute. *Sex and America's Teenagers*. (New York: The Alan Guttmacher Institute,1994).

Thompson, S., "Putting a Big Thing into a Little Hole: Teenage Girls' Accounts of Sexual Initiation," *Journal of Sex Research*, 27:3 (1990): 341-61.

Winship, E. *Reaching Your Teenager*. (N.Y.: Houghton Press, 1983).

Zelnik, M. and Shah, F. K., "First Intercourse Among Young Americans," *Family Planning Perspectives*, 15:2 (1983): 64-68.

Teen quotes are from newspaper, journal, and magazine articles.

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